U.S. Department of Labor

Office of Administrative Law Judges
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Issue Date: 18 September 2007

CASE NO.: 2005-BLA-5882

In the Matter of:

R.S.,
Claimant

v.

HELEN MINING CO.,
Employer

and

DIRECTOR, OFFICE OF WORKERS' COMPENSATION PROGRAMS,
Party-in-Interest

Appearances

Ron Carson, Lay Representative,
For the Claimant

William Mattingly, Esq.
For the Employer

Before: MICHAEL P. LESNIAK
Administrative Law Judge

DECISION AND ORDER – DENYING BENEFITS

This proceeding arises from a claim for benefits under the Black Lung Benefits Act, Title IV of the Federal Coal Mine Health and Safety Act of 1969, as amended, 30 U.S.C. § 901 *et seq*. (Act). The Act and implementing regulations, 20 C.F.R. Parts 410, 718, and 725 (Regulations), provide compensation and other benefits to coal miners who are totally disabled by pneumoconiosis and to the surviving dependents of coal miners whose death was due to pneumoconiosis.

The Act and Regulations define pneumoconiosis (commonly known as black lung disease, coal workers' pneumoconiosis, or CWP) as a chronic dust disease of the lungs and its

sequelae, including respiratory and pulmonary impairments arising out of coal mine employment. 20 C.F.R. § 725.101.

All findings of fact and conclusions of law herein are based upon my thorough analysis and review of the entire record, arguments of the parties, and applicable statutes, regulations, and case law. Each exhibit entered in evidence, although possibly not mentioned in this Decision, has been carefully reviewed and considered in light of its relevance to the resolution of a contested issue. The resolution of black lung benefit claims frequently requires the evaluation and comparison of conflicting evidence. Where evidence may appear to conflict with the conclusions in this case, the appraisal of the relative merits and evidentiary weight of all such evidence was conducted strictly in accordance with the quality standards and review procedures set forth in the Act, Regulations, and applicable case law.

PROCEDURAL HISTORY

Claimant filed this claim for benefits, his first, with the Department of Labor (DOL) on April 13, 2004. (DX-2).[1] The District Director issued a Proposed Decision and Order on January 25, 2005, in which he denied benefits. (DX-24). Claimant disagreed with the decision and requested a revision. (DX-30). On February 23, 2005, the District Director issued a Revised Decision and Order, again denying benefits. (DX-31). On March 3, 2005, Claimant appealed the decision and requested a hearing. (DX-34). This matter was transferred to the Office of Administrative Law Judges on May 18, 2005. (DX-42).

A formal hearing was held on October 31, 2006 in Pittsburgh, Pennsylvania. At hearing, all parties were given full opportunity to present evidence and argument, as provided in the Act and Regulations. Claimant's lay representative indicated that Claimant was unable to attend the hearing as he was suffering from terminal stomach cancer. (TR 18). At the hearing, Director's exhibits 1-44, Claimant's exhibits 1-6 and 9-12, and Employer's exhibits 1-9, 11-16, 18-27, 29, 31-36, 38-39 and 43 were admitted into evidence. (TR 9-16). Claimant's exhibits 7 and 8, letters from Claimant's treating physician, were excluded as exceeding the evidentiary limitations for medical reports. *See Presley v. Clinchfield Coal Co.,* BRB. No. 06-0761 BLA (Apr. 30, 2007). Employer's exhibits 40 and 41 were submitted post-hearing and were received on December 14, 2006 and December 18, 2006 respectively. Both exhibits have been admitted to the record.

At the hearing, a ruling on Employer's exhibit 28, a reading of a digital x-ray, was reserved. (TR 14-15). In *Webber v. Peabody Coal Co*., 23 BLR 1-123 (2006) (*en banc*) the Board determined that digital x-rays are properly considered as "other medical evidence" under 20 C.F.R. § 718.107. A party seeking to admit a digital reading must establish that it is "medically acceptable and relevant to establishing or refuting a claimant's entitlement to benefits." *Harris v. Old Ben Coal Co*., 23 B.L.R. 1-98, BRB No. 04-0812 BLA (Jan. 27, 2006). As the Employer has not presented any evidence relative to the digital x-ray readings and their medical acceptability or relevance, I find that the digital x-ray reading by Dr. Wiot must be

[1] The following abbreviations are used in this opinion: DX = Director's exhibit, EX = Employer's/Carrier's exhibit, CX = Claimant's exhibit, TR = Transcript of the October 31, 2006 hearing, BCR = Board-certified radiologist, B = NIOSH-certified B-reader.

excluded. Likewise, the rebuttal reading of this digital x-ray performed by Dr. Gohel is excluded.

At the hearing, Employer was limited to one report of each CT scan, and accordingly, Employer's exhibits 17 and 37 were excluded. In choosing one interpretation of each CT scan, Employer stated that it preferred the interpretation of a June 13, 2005 CT scan performed by Dr. Wiot over the report of Dr. Meyer. On reviewing the records, I note that the Employer has submitted a third interpretation of this CT scan, performed by Dr. Renn. (EX-14). As the Employer has indicated that it prefers the CT scan report of Dr. Wiot, and the Employer is limited to one report of each CT scan, the report of Dr. Renn is hereby excluded from evidence.

Claimant indicated on his Evidence Summary Form that he was offering two interpretations of the x-ray taken on November 23, 2005 as affirmative x-ray evidence. However, Claimant has also submitted the medical report of Dr. Schaaf, which includes the physician's interpretation of an x-ray taken on March 8, 2005. This interpretation would constitute the third affirmative x-ray and the reading of this x-ray has not been considered as evidence in this claim. Employer's Exhibit 42, a rebuttal re-reading of Dr. Schaaf's x-ray was received post-hearing on December 18, 2006, and has not been admitted.

The Employer indicated on the evidence summary form that it was submitting an interpretation by Dr. Shipley of the June 21, 2004 x-ray and an interpretation of the May 25, 2005 x-ray by Dr. Wiot as affirmative evidence. Dr. Fino's medical report includes an interpretation of an x-ray performed with his examination, which would constitute the third affirmative x-ray from the employer in this claim, and, therefore, this x-ray interpretation is not considered. Dr. Renn's medical report also includes an interpretation of the May 25, 2005 x-ray, performed as part of Dr. Renn's examination, which exceeds the evidentiary limits and is not considered.

I received Employer's closing argument on January 17, 2007 and Claimant's closing argument on January 16, 2007. I have considered both arguments in rendering my decision.

The parties stipulated as follows: this claim was filed on April 13, 2004; this is Claimant's first application for benefits; Claimant worked at least 21 years as a coal miner with Helen Coal Company; Claimant has one dependent, his wife, for purposes of augmentation; and Helen Mining Company is the responsible operator. (TR 16-17).

ISSUES

1) Whether this claim was timely filed;

2) Whether Claimant engaged in coal mine employment post-1969;

3) Whether Claimant's last cumulative one year of employment was with the named Responsible Operator;

4) Whether the Employer has secured insurance;

5) Whether Claimant has pneumoconiosis;

6) Whether Claimant's pneumoconiosis arose out of his coal mine employment;

7) Whether Claimant is totally disabled; and

8) Whether Claimant's total disability is due to pneumoconiosis.

(DX-42; TR 17)[2]

FINDINGS OF FACT AND CONCLUSIONS OF LAW

Timeliness

Under 20 CFR § 725.308(a), a claim of a living miner is timely filed if it is filed "within three years after a medical determination of total disability due to pneumoconiosis" has been communicated to Claimant. 20 CFR § 725.308(c) creates a rebuttable presumption that every claim for benefits is timely filed. The Employer has not submitted any evidence to rebut the presumption that this claim was timely filed. Therefore, I find that Claimant's application for benefits was timely filed.

Length of Coal Mine Employment

Employer has stipulated to at least 21 years of coal mine employment with Helen Mining. (TR 16-17). The District Director found 21.87 years of coal mine employment. (DX-31). I find that the record is consistent with the District Director's findings. (DX-3, 4, 5, 7). Thus, I find that Claimant was a coal miner within the meaning of the Act for at least 21.87 years.

Responsible Operator; Post-1969 Employment; Last Cumulative One Year of Employment; Insurance

Employer has stipulated, and I find, that Helen Mining Company is properly-named as the Responsible Operator. (TR 16-17). Employer has contested the issues of whether Claimant was employed as a miner post-1969 and whether Claimant's last cumulative one year of employment was with Employer. The record contains a letter from Employer, Claimant's own report of his coal mine employment, and the Social Security records; each indicate that Claimant worked for Helen Mining from 1971 to 1993. No further coal mine employment is listed after 1993. Therefore, I find that Claimant worked in coal mine employment after 1969 and that his last cumulative one year period of employment was with the named Employer. Finally, there is nothing in the record to show that the Employer is uninsured.

[2] The Employer also contests additional issues as listed under #18 on Form CM-1025 which are hereby preserved for purposes of appeal.

Date of Filing

The parties stipulated and I find that Claimant filed this claim for benefits under the Act on April 13, 2004. (DX-2; TR 16-17).

Augmentation

The parties stipulated and I find that Claimant has one dependent for purposes of augmentation, his wife. (TR 16-17).

Testimony

As discussed above, Claimant was unable to attend the hearing due to terminal cancer. The Employer has submitted Claimant's answers to interrogatories as evidence in this claim. (EX-2). In his answers, Claimant indicated that he smoked for 28 years and that he began smoking at age 19. He quit for a period of five years from 1979 until 1983. He indicated that he smoked less than a ½ of cigarettes per day, that he quit smoking in 2000 and that he is not currently smoking. He stated that his breathing problems have been ongoing and progressively getting worse. Claimant further stated that he is constantly coughing and spitting up gray mucous and that with any activity he has to stop and catch his breath. He first described his breathing problems to Dr. Celko in August 2004.

Claimant indicated that his last job in the mines was as a shuttle car operator where he hauled coal from the mining machine at the face to the conveyor belt. He also rock dusted and set timbers. Prior to that, he worked as a roof bolter for 17 years where he drilled and installed roof bolts to support the roof. He also installed post rails, rock dusted and carried and loaded supplies. (EX-2).

Medical Evidence

Chest x-rays

Exhibit	**x-ray Date**	**Date Read**	**Physician/ Qualifications**	**Interpretation**
DX-12	6-21-04	6-21-04	Koecher, B	1/0, t/s; lower 4 zones
DX-13	6-21-04	9-1-04	Barrett, BCR, B	Quality only; quality 1
EX-1	6-21-04	3-9-05	Wiot, BCR, B	Negative
EX-11	6-21-04	6-9-05	Shipley, BCR, B	Negative
CX-3	6-21-04	10-26-05	Gohel, BCR, B	1/0; s/t; lower 4 zones
CX-2	5-25-05	10-28-06	Gohel, BCR, B	1/0; t/s; lower 4 zones
EX-15	5-25-05	9-17-05	Wiot, BCR, B	Negative
CX-1	11-23-05	12-06-05	Gohel, BCR, B	1/0; t/s; lower 4 zones
EX-43	11-23-05	10-20-06	Scott, BCR, B	Negative
CX-9	11-23-05	10-12-06	Colella, BCR, B	1/0; t/s; lower 4 zones

CT Scans

Dr. Shyam Gohel reviewed a CT scan performed on January 12, 2005 and noted faint infiltrate in the right middle lobe lingual. He indicated that "[d]ifferential diagnostic considerations would include fibrosis and subsegmental atelectasis." (CX-11 p.2). No pleural effusion was found. (CX-11). He further stated that, "[n]o definite CT evidence of pneumoconiosis is identified on this exam. It should be noted, however, that a high resolution protocol was not utilized and therefore detection of subtle interstitial lung disease would not be possible on this exam." (CX-11, p.2).

Dr. Gohel also reviewed a CT scan performed on June 13, 2005 at Indiana Hospital. He found infiltrate/fibrosis in the right middle lobe lingula and to a lesser extent the left lower lobe. He indicated "[d]ifferential diagnostic considerations would include fibrosis, subsegmental atelectasis or less likely pneumonia." (CX-11, p.1). There was no pleural effusion. He indicated high resolution scans were not performed and therefore evaluation for interstitial lung disease is not possible on this exam. (CX-11, p.1). Dr. Gohel is a board-certified radiologist and B-reader. (CX-1).

Dr. Paul Wheeler reviewed the January 12, 2005 CT scan. He determined that there was no pneumoconiosis. He found moderate obesity including intra-abdominal and mediastinal deposits, and probable fatty liver disease that he felt should be checked clinically. (EX-33). Dr. Wheeler is board-certified in radiology and is a B-reader. (EX-36).

Dr. Jerome Wiot reviewed the June 13, 2005 CT scan. He concluded that although there was linear stranding in the right middle lobe and the lingual was consistent with old scarring, there was no evidence of pneumoconiosis. (EX-21). Dr. Wiot is a board-certified radiologist and B-reader. (EX-3).

Pulmonary Function Studies

Exhibit	**Date**	**Height**[3]	**Age**	**FEV_1**	**FVC**	**MVV**	**FEV_1/FVC**	**Qualifying?**
DX-12	6-21-04	67.5"	56	2.13 2.35*	2.70 2.91*	-- --	79% 81%	No No
CX-4	3-8-05	66"	57	2.18	3.03	--	72%	No
EX-9	5-25-05	67"	57	2.12 1.96*	2.80 2.51*	56 62*	76% 78%	No No
EX-26	11-8-05	66"	57	2.10	2.77	--	76%	No
CX-5	11-23-05	67.5	57	2.28 2.31*	2.92 2.82*	-- --	78% 82%	No No

*Post-bronchodilator value

[3] The fact-finder must resolve conflicting heights of Claimant recorded on the ventilator study reports in the claim. *Toler v. Easter Assoc. Coal Co.*, 43 F.3d 109 (4th Cir. 1995); *Protopappas v. Director, OWCP*, 6 BLR 1-221 (1983). As there is a variance of 1.5" in the recorded height of Claimant, I have used 66.75" because it is the average of the recorded heights. All of the pulmonary function studies produced non-qualifying results using both the height recorded and the average height.

Dr. James Castle reviewed the June 21, 2004 PFT and determined that it was a valid study. He found the evidence showed a mild reduction in the forced vital capacity and FEV1, without large airway obstruction. He found the total lung capacity mildly reduced and the diffusing capacity normal. (EX 25). Dr. Castle is board-certified in internal medicine, pulmonary disease and is a B-reader. (EX-27).

Dr. Joseph Renn reviewed the pulmonary function study performed on March 8, 2005. He determined that the FEV1 was underestimated due to both a failure to maintain maximal effort throughout one of the entire FVC maneuvers and an unsatisfactory start of expiration. He also found the practical limit of the eight FVC maneuvers was not provided to result in three acceptable studies. He further found the study was performed one week past the last calibration of the equipment. Based on these reasons, Dr. Renn found the study invalid by the American Thoracic Society criteria for accurate interpretation of true ventilatory function. He concluded that the values represent less than Claimant would be capable of with complete cooperative effort. (EX-34).

Dr. Renn also reviewed the spirometry study performed on November 23, 2005. He found the source of the reference values were not indicated on the report. He found that Claimant had an unsatisfactory start of expiration which resulting in underestimation of the FEV1, and a normal FEV1/FVC ratio. However, Dr. Renn determined that despite those technical deficiencies, the study was valid and constituted an accurate representation of Claimant's true ventilatory function, which Dr. Renn found consistent with moderate restriction. (EX-35).

Dr. Evan Restelli administered the November 23, 2005 PFT. Based on the exam, Dr. Restelli concluded that Claimant had no obstruction demonstrated by the lung study. He found that Claimant had a mild lung volume restriction and showed no response to bronchodilators. He found Claimant's diffusing capacity normal. (CX-5, p.1). Dr. Restelli is board-certified in internal medicine and board-eligible in pulmonary disease. (CX-5).

Arterial Blood Gas Studies

Exhibit	**Date**	**PCO2**	**PO2**	**Qualifying?**
DX-12	6-21-04	42 43	65 82	No No
EX-9	5-25-05	40	68	No
EX-26	11-8-05	38	71	No

Medical Reports[4]

Dr. Celko

Dr. David Celko examined Claimant on June 21, 2004. He reviewed Claimant's coal mine employment and smoking histories, noting that Claimant smoked ½ pack per day for 34 years. Dr. Celko noted Claimant's complaints of wheezing, sputum production, dyspnea and cough. During examination, a PFT, an arterial blood gas study ("ABG") and a chest x-ray were performed. The x-ray was interpreted by Dr. Mark Colella, a B-reader and Board Certified Radiologist, as positive for pneumoconiosis. The PFT showed a moderate obstructive pattern and the ABG studies showed resting hypoxemia and normal exercise response. Dr. Celko diagnosed chronic asthmatic bronchitis which he attributed to cigarette smoking, occupational dust exposure and gastroesophogeal reflux disease ("GERD") syndrome. He indicated that Claimant is disabled from his last mining job as a roofbolter. Dr. Celko that he could not distinguish the individual contribution of Claimant's smoking and coal mine dust exposure histories to Claimant's impairment. He stated that historically and roetgeographically, the dust exposure seems to be the major contributor to the impairment. Dr. Celko is board-certified in internal medicine. (DX-12).

Dr. Celko wrote a letter dated October 21, 2004 in response to Claimant's request for clarification of his opinion. Dr. Celko stated that Claimant suffers from coal workers' pneumoconiosis. He stated that Claimant is 56 years old and spent 21 years in coal mine employment. He stated that Claimant has significant respiratory symptoms, including a moderate obstructive lung disease, with only a modest smoking history. He stated that his opinion was based on both a 21 year history of coal mine employment and Claimant's symptoms, including cough, wheezing and dyspnea, which are consistent with chronic lung disease. Dr. Celko further noted that the PFT showed moderate obstructive lung disease, and the ABG study showed hypoxemia, which is an impairment consistent with smoking and coal mine employment. He stated that even if the Claimant did not have x-ray evidence of pneumoconiosis, his opinion that Claimant has coal workers' pneumoconiosis would not change. (DX-14; CX-6).

Dr. Celko testified at a deposition on June 23, 2005. He explained that Claimant had attacks of wheezing for 15 years, which indicated some underlying reactive reversible airway disorder. He also opined that Claimant had GERD which could affect pulmonary capacity and could explain part of the symptomology of cough and mucous production. Dr. Celko noted that he did not have enough information to determine whether GERD was contributing to Claimant's pulmonary complaints, since he had only examined Claimant once. Dr. Celko indicated that if Claimant's smoking history was 34 years of 1 to 1 ½ packs per day, instead of just ½ pack per day, he would be more worried that tobacco consumption had caused the respiratory symptoms. Dr. Celko indicated that the PFT showed a slight reversibility with bronchodilators and obstruction with air trapping. He stated that Claimant could do moderate physical activity from a

[4] Medical reports and/or physicians' testimony which refer to documents not in evidence are deemed to have been redacted. Unless I make a specific finding herein that the redacted data is critical to a physician's ultimate opinion, the redaction of objectionable information will not materially affect the weight I accord such opinion. *See Harris v. Old Ben Coal Co.*, 23 BLR 1-98, BRB No. 04-0812 BLA (Jan. 27, 2006); *see also, Webber v. Peabody Coal Co.*, 23 BLR 1-123, BRB No. 05-0335 BLA (Jan. 27, 2006)(en banc).

ventilatory standpoint, with some limitation. He explained that, although the x-ray was read as positive for pneumoconiosis, the findings were not typical and he would not diagnose clinical pneumoconiosis. He further stated that there was not a sufficient basis to make a determination of legal pneumoconiosis, and although there was pulmonary impairment, there were several potential causes including smoking, occupational dust exposure and GERD. He indicated that he would have to do further testing to determine the cause of Claimant's impairment. He found Claimant was not totally disabled from a pulmonary standpoint. (EX-8).

Dr. Renn

Dr. Joseph Renn examined Claimant on May 25, 2005. Dr. Renn indicated that Claimant worked for more than 20 years in underground coal mining as a roofbolter, continuous miner operator and shuttlecar operator. Claimant reported having shortness of breath and exertional dyspnea since 1990, daily productive cough since 1998, and wheezing which began around 1999 and had continued to worsen since 2003. Dr. Renn reviewed Claimant's medical records and noted that Claimant smoked ½ pack of cigarettes daily for 28 to 34 years, the equivalent of 14 to 17 pack years. On physical examination, Dr. Renn found Claimant's lungs clear. He also noted that Claimant was severely overweight. Dr. Renn concluded that Claimant's spirometry and lung volumes were consistent with a mild restrictive ventilatory defect and that the diffusing capacity was normal. Dr. Renn found the MVVs invalid as they did not correlate with the contemporaneously performed FEV1. He found the resting ABG normal and the carboxyhemoglobin test consistent with a non-smoker. Dr. Renn performed an x-ray as part of his examination of Claimant. He interpreted the x-ray as negative for pneumoconiosis. Dr. Renn also reviewed Dr. Celko's evaluation, work history records, and other medical records.

Based on the evidence he reviewed, Dr. Renn diagnosed chronic bronchitis due to tobacco smoking, mild restrictive ventilatory defect due to obesity and GERD. He did not diagnose pneumoconiosis. Dr. Renn concluded that Claimant is not totally and permanently disabled and, from a respiratory standpoint, Claimant could perform the work of a shuttlecar operator or a roofbolter. (EX-9). Dr. Renn is Board certified in internal medicine, pulmonary disease, forensic medicine, and is a forensic medical examiner and a B-reader. (EX-13).

Dr. Renn testified at a deposition on December 7, 2006. Dr. Renn again discussed the requirements of Claimant's coal mine employment and determined that although Claimant has some pulmonary impairment, he is able to perform the requirements of his last job. (EX-41, p.7). His determination was based on a normal diffusing capacity and a mild reduction in FEV1, which would not prevent Claimant from performing manual labor. (EX-41, p.7). Dr. Renn stated that Claimant has chronic bronchitis, which he attributed to Claimant's smoking and severe obesity. (EX-41, p.8). He stated that Claimant's symptoms are not a typical presentation of chronic bronchitis caused by exposure to coal mine dust, "[b]ecause chronic bronchitis or industrial bronchitis caused by exposure to coal mine dust begins early on during exposure…continues throughout the time of exposure and then it disappears completely within six months to a year after [the miner] is no longer exposed." (EX 41, p.9). Dr. Renn further stated that he could not attribute any of Claimant's pulmonary impairment to his years of cigarette smoking because "[Claimant] doesn't have obstructive airways disease. He has restrictive airways disease and cigarette smoking causes only obstructive airway disease." (EX-41, p.11). Dr. Renn disagreed with Dr. Schaaf's determination that Claimant is disabled from a pulmonary standpoint. He stated that the degree of Claimant's restriction is not severe enough to

cause a decrease in FEV1 sufficient to prevent Claimant from heavy manual labor. He further stated that Claimant has normal oxygenation on exercise, which is consistent with obesity when ventilation perfusion abnormalities are corrected with exercise. (EX-41, p.17).

Dr. Fino

Dr. Gregory Fino examined Claimant on November 22, 2005 and prepared a report of his findings. Dr. Fino noted Claimant's medications, his past medical history and his family history. He indicated that Claimant worked in the coal mining industry for 22 years, spending all of his time underground. He noted that Claimant's last job was as a shuttle car operator and, prior to that, Claimant worked for 17 years as a roofbolter. Dr. Fino noted that Claimant was currently working as a custodian, a job involving heavy lifting and mopping. Claimant reported having shortness of breath for the last 15 years which continued to worsen. Claimant reported having difficulty climbing one flight of stairs, walking on hills and grades, lifting and carrying, performing manual labor and walking briskly on level ground. Claimant also reported daily cough and mucous production. On examination, Dr. Fino found Claimant's lungs clear. Claimant's PFT showed spirometry with a mild reduction in FVC and FEV1. His lung volumes and diffusing capacity were normal. Claimant's ABG study was normal.

Dr. Fino also reviewed Claimant's medical records, including Dr. Celko's examination and deposition, and Dr. Renn's examination report. Based on examination and his review of the medical evidence, Dr. Fino made the following diagnoses:

1. Reductions in the FVC & FEV1 consistent with obesity
2. A history of daily cough and mucous production without any other objective evidence of an obstructive defect
3. Widening of the right mediastinum

(EX 26, p.9).

Dr. Fino concluded that Claimant does not suffer from pneumoconiosis. His conclusion was based on: his own negative x-ray reading of the chest x-ray; the additional negative chest x-ray evidence he reviewed; the slight restrictive abnormalities noted on the exams, which he found consistent with obesity; the normal diffusing capacities, which rules out the presence of clinically significant pulmonary fibrosis; and, the lack of impairment in oxygen transfer when Claimant exercised. Based on the lack of ventilatory impairment, the normal diffusing capacity and the normal ABG study showing no hypoxemia or oxygenation problems, Dr. Fino opined that Claimant's pulmonary system is normal and that he retains the capacity to perform all the requirements of heavy sustained labor. (EX-26). Dr. Fino is board-certified in internal medicine and pulmonary disease and is a B-reader. (EX-26).

Dr. Fino testified at deposition on October 30, 2006. He stated that Claimant was taking a whole series of medications but that the only prescriptions used to treat lung disease were Claimant's two inhalers. He explained that the inhalers are used for reversible airway obstruction, not for treating pneumoconiosis which causes a fixed, irreversible impairment. He further stated that one of the antibiotics Claimant was taking can cause significant pulmonary problems and a reduction in spirometry as a side effect. Dr. Fino testified that Claimant's coal mine work and smoking histories were both risk factors for developing lung disease. He

indicated that Claimant had GERD, which can cause cough and pulmonary fibrosis. He noted that Claimant's body mass index meets the criteria for obesity which can also cause breathing problems. He explained that Claimant had plate-like atelectasis, which is a condition in which a portion of the lung does not expand properly. Dr. Fino stated that this condition may be related to Claimant's obesity but is not caused by his coal mine employment. He stated that the PFT showed that the lungs were expanding properly, indicating no fibrosis, and that the pattern was classic for an obese patient. Dr. Fino explained that the testing showed no evidence of a smoking induced lung disease, but that the changes in the lower and middle lung zones, as described on the CT scan, are due to smoking. Dr. Fino disagreed with Dr. Celko's determination that there was an obstructive impairment because there was not a marked reduction in the FEV1 to FVC. He stated that lung volumes would need to be performed to determine if Claimant has a true restriction due to pulmonary fibrosis or only a restrictive-like abnormality. He stated that he would not diagnose chronic bronchitis because although Claimant had daily cough and mucous production, there was no abnormality on the lung examination consistent with obstruction due to chronic bronchitis. He noted that the lung function study showed no more than a mild reduction in the FVC and FEV1 with no oxygen transfer abnormality, and concluded that Claimant had the respiratory capacity to perform heavy manual labor. (EX-39).

Dr. Schaaf

Dr. John Schaaf examined Claimant on March 8, 2005 and prepared a report of his findings. He reported that Claimant worked for 22 years in underground coal mining, first as a roof bolter, then as a miner operator and, finally, as a shuttle car operator. Dr. Schaaf indicated that Claimant smoked about a ½ pack of cigarettes per day for 32 years, quitting in April 2000. Claimant reported complaints of wheezing, coughing and shortness of breath, along with daily cough and sputum production. Claimant indicated he could walk one or two blocks on a level surface and up one flight of stairs, but not two. Dr. Schaaf administered a PFT which showed a mild restrictive defect and no obstruction. He also reviewed the June 21, 2004 pulmonary function and ABG studies, administered by Dr. Celko, and the June 21, 2004 x-ray interpretation by Dr. Koecher.

Dr. Schaaf diagnosed coal workers' pneumoconiosis, based on his own x-ray interpretation and a compatible history of coal mine employment. (CX-4, p.4). Dr. Schaaf read his own x-ray as, "abnormal with scattered nodular and linear opacities in the lower lung zones." (CX-4, p.3). He classified the opacities as Q/T with a 1/0 profusion, and found the x-ray abnormalities consistent with pneumoconiosis. (CX-4, p.3). Dr. Schaaf diagnosed chronic bronchitis with an unclear etiology, but opined that it was related to Claimant's coal mine employment. He also diagnosed restrictive physiology and hypoxemia, which, he concluded, left Claimant incapable of performing his last coal mine employment. Dr. Schaaf opined that Claimant's restrictive physiology and hypoxemia were due to his coal workers' pneumoconiosis. Dr. Schaaf considered Claimant's smoking history an etiology of his chronic bronchitis, but noted that Claimant's smoking history is minimal, his bronchitis is moderate to severe, and the bronchitis arose during Claimant's coal mine employment with no change after Claimant quit smoking. Dr. Schaaf is board-certified in internal medicine and pulmonary disease. (CX-4).

Dr. Schaaf testified at deposition on November 17, 2006. He indicated that in addition to his examination and testing, he reviewed other medical data including Dr. Celko's examination.

Dr. Schaaf indicated that although medical standards classify Claimant as obese, he would have to examine Claimant to determine whether his weight was causing his medical problems. He disagreed that obesity can cause shortness of breath but agreed that obesity can cause abnormalities on spirometry, specifically a reduction in the FVC, which is a restrictive defect. He stated that Claimant had a mild restrictive defect with no airflow obstruction. Dr. Schaaf did not perform an ABG study, but reviewed the results of the June 21, 2004 study. Dr. Schaaf noted that Claimant had an abnormally low PO2 at rest, and that although the ABG showed a normal response to exercise, the fact that the PO2 rose with exercise suggested additional lung impairment.

Dr. Schaaf explained that while morbidly obese patients have a PO2 lower than normal, mildly obese patients do not. He concluded that Claimant had hypoxemia based on a PO2 of 65. He attributed the hypoxemia to coal workers' pneumoconiosis based on Claimant's x-ray evidence and the lack of an alternative explanation. He stated that he felt Claimant's total lung capacity, as demonstrated by the June 2004 spirometry, was abnormal. Dr. Schaaf reiterated that Claimant suffered from moderate to severe chronic bronchitis based on Claimant's chronic cough and sputum production. He stated that chronic bronchitis does not necessarily cause obstruction and that it has not caused obstruction in this case. Dr. Schaaf concluded that Claimant is unable to perform his usual coal mine employment based on his significant hypoxemia and restrictive physiology, and his chronic cough and sputum production. (EX-40).

Medical Records

Hospitalization records from Indiana Hospital dated June 1990, indicate that Claimant was admitted for hearing loss, ringing in the ear, chest pain and complaints of a choking sensation. The chest pain was attributed to angina, diffuse vascular disease and smoking. Claimant reported smoking one pack per day at that time. The hospital records include an x-ray which was not performed for the purpose of diagnosing pneumoconiosis. (EX-4).

An x-ray read by Dr. Sang Oh, dated August 1991, is included in Claimant's treatment records, but it was not specifically performed for the diagnosis of pneumoconiosis. (EX-12).

Medical records from Alleghany General Hospital include records of a visit on August 31, 1991 for what the Claimant describes as "a feeling of his lungs being full." Claimant was given Mylanta and Xanax. Claimant reported to Alleghany General again on September 5, 1991 for bouts of fullness triggered by food ingestion. Dr. Mitre opined that Claimants symptoms were more consistent with GI pathology than a cardiac event. (EX-23). Claimant was given a Gastrointestinal Endoscopy on September 6, 1991. (EX-23).

Medical reports dated September 9, 1991, from Dr. Floyd M. Cassidy, diagnosed Claimant with early heptic cirrhosis and chronic GERD. (EX-24).

Claimant was treated by Dr. Minoo D. Karanjia in June 1993 for complaints of throat problems, headaches, and sinusitis. (EX-5). Claimant returned to Dr. Karanjia on October 24, 1996 with complaints of headaches, which had been occurring since March 1996, and a cough which had been occurring for the last month. Both a CT scan and chest x-ray were performed and the results were normal. (EX-5).

An MRI was performed on July 14, 2000 and compared to earlier CT studies dated November 11, 1996 and December 7, 1995. Dr. Frank Papa concluded that the MRI showed no abnormalities involving the brain or IAC's. (EX-6).

A chest x-ray was taken on January 12, 2005 at Indiana Regional Medical Center. The x-ray was not performed for the purpose of diagnosing pneumoconiosis. (EX-19).

Claimant was treated by Dr. Ravi Nadarajah in February 2005. Claimant complained of persistent phlegm in his throat and post-nasal drip. A laryngoscopy was performed resulting in a diagnosis of sinusitis and bilateral inferior turbinate hypertrophy. (EX-7).

Claimant was treated at the Veteran's Area Medical Center on March 21, 2005 by Dr. S. Rashmikant Pandit. Dr. Pandit conducted a PFT which yielded nonqualifying results. Dr. Pandit noted that the PFT showed no obstructive defect but he stated that he could not exclude a restrictive defect based on the spirometry alone. He noted that the diffusion capacity was within normal limits. (EX-20).

Claimant was treated by Dr. Matthew Nettleton from March 2005 to August 2006 for issues related to Claimant's treatment for throat cancer. Claimant underwent both surgery and chemotherapy to treat his cancer. (EX-32).

Standard of Review

The administrative law judge (ALJ) need not accept the opinion of any particular medical witness or expert, but must weigh all the evidence and draw his/her own conclusions and inferences. *Lafferty v. Cannelton Industries, Inc.*, 12 BLR 1-190 (1989). The adjudicator's function is to resolve the conflicts in the medical evidence; those findings will not be disturbed on appeal if supported by substantial evidence. *Id*. In considering the medical evidence of record, an ALJ must not selectively analyze the evidence. *See Wright v. Director, OWCP*, 7 BLR 1-475 (1984); *Hess v. Clinchfield Coal Co.*, 9 BLR 1067 (1986).

Entitlement to Benefits

This claim was filed after March 31, 1980 and is therefore adjudicated under the regulations at 20 C.F.R. § 718. Under this Section, a claimant must establish, by a preponderance of the evidence, that he has pneumoconiosis, that his pneumoconiosis arose from coal mine employment, and that he is totally disabled due to pneumoconiosis. Failure to establish one of these elements precludes entitlement to benefits. 20 C.F.R. §§ 718.202-205; *Perry v. Director, OWCP*, 9 BLR 1-1 (1986). This claim was filed after January 19, 2001 and is governed by the amended regulations.

Existence of Pneumoconiosis

The Regulations define pneumoconiosis broadly, as "a chronic disease of the lung and its sequelae, including respiratory and pulmonary impairments arising out of coal mine employment." 20 C.F.R. § 718.201. The Regulations' definition includes not only medical, or "clinical," pneumoconiosis but also statutory, or "legal," pneumoconiosis. *Id.* Clinical pneumoconiosis comprises:

> [T]hose diseases recognized by the medical community as pneumoconiosis, i.e., the conditions characterized by permanent deposition of substantial amounts of particulate matter in the lungs and the fibrotic reaction of the lung tissue to that deposition caused by dust exposure in coal mine employment. This definition includes, but is not limited to, coal workers' pneumoconiosis, anthracosilicosis, anthracosis, anthrosilicosis, massive pulmonary fibrosis, silicosis, or silicotuberculosis arising out of coal mine employment.

Id.

Legal pneumoconiosis, on the other hand, includes "any chronic lung disease or impairment and its sequelae arising out of coal mine employment." *Id.* "[A] disease 'arising out of coal mine employment' includes any chronic pulmonary disease or respiratory or pulmonary impairment significantly related to, or substantially aggravated by, dust exposure in coal mine employment." *Id.* Finally, the Regulations recognize that pneumoconiosis is "a latent and progressive disease" that might only become detectable after a miner's exposure to coal dust cases. *Id.* In the face of conflicting evidence, I shall weigh all of the evidence together in finding whether Claimant has established that he has pneumoconiosis. *Island Creek Coal Co. v. Compton*, 211 F.3d 203, 211 (4th Cir. 2000).

Section 718.202 provides four means by which pneumoconiosis may be established. Under § 718.202(a)(1), a finding of pneumoconiosis may be made on the basis of the x-ray evidence. The x-ray evidence admitted to record consists of nine x-ray interpretations of three separate chest x-rays, and one reading made for quality only. Each of the individual x-rays were interpreted as both positive and negative. Dr. Koecher, a B-reader, and Dr. Gohel, who is dually-qualified interpreted the June 21, 2004 x-ray as positive for pneumoconiosis, while Drs. Wiot and Shipley, both dually qualified physicians, interpreted the film as negative. Dr. Wiot found the May 25, 2005 film negative while Dr. Gohel, interpreted the film as positive. The final film, taken on November 23, 2005 was interpreted as positive by Drs. Gohel and Colella, and as negative by Dr. Scott.

In evaluating the chest x-ray interpretations, the qualifications of the physicians reading the x-rays must be taken into account. 20 C.F.R. § 718.202(a)(1). The x-ray interpretations of physicians who are board-certified radiologists and B-readers are entitled to the greatest weight. *Sheckler v. Clinchfield Coal Co.*, 7 BLR 1-128 (1984). Based on the qualifications and experience of each physician who submitted an x-ray interpretation in this case, I find that the x-ray evidence is in equipoise and that Claimant has not established the existence of pneumoconiosis by a preponderance of the x-ray evidence. Therefore, I find that Claimant has not established the presence of pneumoconiosis under § 718.202(a)(1).

Under § 718.202(a)(2), a finding of pneumoconiosis may be made on the basis of biopsy or autopsy evidence. In the present case, no biopsy evidence was submitted. Further, the Claimant is still living, therefore no autopsy evidence has been submitted. Accordingly, Claimant has not established the presence of pneumoconiosis under § 718.202(a)(2).

Section 718.202(a)(3) provides that pneumoconiosis may be established if any one of several cited presumptions are found applicable. In the instant case, the presumption of § 718.304 does not apply because the x-ray evidence does not establish complicated

pneumoconiosis. Section 718.305 is inapplicable to claims filed after January 1, 1982. Finally, the presumption of § 718.306 does not apply to living miner's claims. Therefore, the Claimant cannot establish pneumoconiosis under § 718.202(a)(3).

Finally, I consider the Claimant's treatment records, CT scan evidence, and the reports of Drs. Celko, Schaaf, Fino and Renn to determine whether Claimant has established the existence of pneumoconiosis.

Under § 718.202(a)(4), a determination of the existence of pneumoconiosis may be made if a physician exercising reasoned medical judgment, notwithstanding a negative x-ray, finds that the miner suffers from pneumoconiosis as defined in § 718.201. Pneumoconiosis as defined in § 718.201 means a chronic dust disease of the lungs and its sequelae, including respiratory and pulmonary impairments, arising out of coal mine employment. *See* 20 C.F.R. § 718.202(a)(1) and (2). The regulations further state that:

> Any such finding shall be based on objective medical evidence such as blood-gas studies, electrocardiograms, pulmonary function studies, physical performance tests, physical examination, and medical and work histories. Such a finding shall be supported by a reasoned medical opinion.

20 C.F.R. § 718.202(a)(4).

Medical reports that are based upon and supported by patient histories, a review of symptoms, and a physical examination constitute adequately documented medical opinions as contemplated by the Regulations. *Justice v. Director, OWCP*, 6 BLR 1-1127 (1984). However, where the physician's report, although documented, fails to explain how the documentation supports its conclusions, an ALJ may find the report to be not a reasoned medical opinion. *Smith v. Eastern Associated Coal Co.*, 6 BLR 1-1130 (1984). A medical opinion is not sufficiently reasoned if the underlying objective medical data contradicts it. *White v. Director, OWCP*, 6 BLR 1-368 (1983).

Numerous medical treatment records, spanning from 1991 to 2005, were submitted. The treatment records include x-ray interpretations that were not read for the purposes of establishing the presence of pneumoconiosis and do not conform to the requirements of § 718.102. I find that these x-ray interpretations are entitled to little weight in determining whether Claimant suffered from clinical pneumoconiosis. Among the treatment records are reports of, and treatment for, esophageal and indigestion problems, sinusitis, chest pain, headaches, cough, and persistent phlegm. The records also contain treatment reports related to Claimant's throat cancer. The records do not, however, contain any diagnosis of pneumoconiosis, nor do they provide a reasoned and/or documented finding of a disease arising out of coal mine employment. Therefore, the medical records standing alone do not establish pneumoconiosis. I find the more relevant evidence to be the medical opinions of Drs. Celko, Schaaf, Renn and Fino.

There are four medical reports in the record. Dr. Celko initially determined that Claimant had pneumoconiosis, based on a positive x-ray reading and Claimant's coal dust exposure history. He also diagnosed asthmatic bronchitis, which he attributed to both coal mine dust and smoking. In his explanation letter Dr. Celko noted that Claimant's symptoms of cough,

wheezing and dyspnea, along with both his moderate obstructive lung disease demonstrated by PFT, and hypoxemia demonstrated by ABG studies, were consistent with both coal mine employment and smoking. However, in his deposition, Dr. Celko indicated that he would not consider the specifics of this x-ray interpretation as diagnostic of pneumoconiosis. Dr. Celko further stated that although Claimant had pulmonary impairment, there were several potential causes of that impairment and there was not sufficient evidence to diagnose legal pneumoconiosis. Dr. Celko initially concluded that Claimant was disabled from his last coal mine job, but, at deposition he opined that Claimant was not totally disabled from a pulmonary standpoint.

Dr. Renn determined that Claimant does not suffer from pneumoconiosis. He diagnosed Claimant with chronic bronchitis due to tobacco smoking and noted a mild restrictive ventilatory defect which he attributed to gastroesophogeal reflux disease ("GERD") and Claimant's obesity. Dr. Renn explained that Claimant's chronic bronchitis is not consistent with coal mine dust exposure, but then, in contradiction to his earlier etiologic conclusions, he explained that Claimants chronic bronchitis was not consistent with smoking either. Dr. Renn concluded that Claimant's restriction is not sufficient to prevent Claimant from performing heavy manual labor and that Claimant is not totally disabled from a pulmonary standpoint.

Dr. Fino also determined that Claimant does not suffer from pneumoconiosis. His conclusion was based on his own negative x-ray reading, as well as a review of the other x-ray readings in evidence, and the nonqualifying PFT and ABG results. He noted that Claimant had slight restrictive abnormalities in his pulmonary function, but Dr. Fino attributed this restriction to Claimant's obesity. Dr. Fino stated that he would not diagnose Claimant with chronic bronchitis because Claimant had no abnormality on his lung examination which would be consistent with obstruction due to chronic bronchitis. Dr. Fino found that the PFT and ABG results were nonqualifying and concluded that Claimant retains the capacity to perform heavy manual labor.

Dr. Schaaf diagnosed pneumoconiosis based on his positive x-ray reading and a compatible history of coal mine employment. He also diagnosed chronic bronchitis, which he indicated in his opinion was related to coal mine dust exposure. Dr. Schaaf reviewed medical data, including Dr. Celko's examination and the resulting PFT and ABG findings. Dr. Schaaf diagnosed hypoxemia based on ABG evidence. He attributed the hypoxemia to Claimant's coal workers' pneumoconiosis based on the x-ray evidence. Dr. Schaaf concluded that Claimant is unable to perform his last coal mine employment based on hypoxemia, restrictive physiology and chronic cough and sputum production.

When evaluating the opinion evidence, I note that Drs. Schaaf, Fino and Renn all provided an x-ray interpretation as part of their medical opinions, but I further note that those x-ray readings exceed the evidentiary limit and are inadmissible. Section 725.414 provides that any x-ray reference in a medical report must be admissible. 20 C.F.R. § 725.414(a)(2),(a)(3)(i). An ALJ may, in his discretion, decline to consider a physician's opinion on the existence of pneumoconiosis if that opinion is "inextricably tied" to an inadmissible x-ray reading. *Dempsy v. Sewell Coal Co.*, 23 BLR 1-47, BRB Nos. 03-0615 BLA-A (Jun. 28, 2004)(*en banc*)(quoting *Clark v. Karst-Robbins Coal Co.*, 12 BLR at 1-149, 1-153 (1989)(*en banc*).

In weighing the medical opinion of Dr. Celko, I note that he initially diagnosed both clinical and legal diagnosis, but at deposition, after a further discussion of the x-ray evidence, he concluded that Claimant did not have clinical pneumoconiosis. He also changed his opinion regarding legal pneumoconiosis, opining that Claimant did not suffer from legal pneumoconiosis. Based on these poorly explained inconsistencies, I give Dr. Celko's opinion less weight.

Dr. Schaaf's opinion is based on a review of the 6/21/04 DOL exam, and his own examination of Claimant. Dr. Schaaf's conclusions regarding pneumoconiosis, both legal and clinical, rely heavily on a positive x-ray interpretation. Dr. Schaaf's own x-ray interpretation is inadmissible because it exceeds the evidentiary limits; however, I note that in his report, Dr. Schaaf also reviewed Dr. Koecher's positive interpretation of the 6/21/04 x-ray, in which Dr. Koecher found t/s opacities in a 1/0 profusion in the lower left lung zones. Therefore, his conclusions are not undermined by reliance on an inadmissible x-ray, and are supported by the underlying medical evidence. Dr. Schaaf also opined that Claimant suffers from chronic bronchitis and hypoxemia due to coal workers' pneumoconiosis. His conclusions were based on x-ray evidence, a PO2 of 65, Claimant's chronic cough and sputum production and the lack of an alternative explanation. I find Dr. Schaaf's opinion well reasoned and documented, however I find that he based his conclusions on a limited review of the record which did not include the most recent x-ray, PFT or ABG evidence. Consequently, I accord Dr. Schaaf's opinion less weight.

I find that Dr. Renn's opinion is not inextricably tied to an inadmissible x-ray reading, and therefore I do not discredit it for that reason. I do note, however, that Dr. Renn's conclusions on the etiology of Claimant's chronic bronchitis, first attributing it to smoking, then finding it unrelated to smoking, are inconsistent. I find Dr. Renn's resulting medical opinion is not well reasoned and I accord his opinion less weight.

I also find that Dr. Fino's opinion is not inextricably tied to an inadmissible x-ray reading, and therefore do not discredit it for that reason. I find Dr. Fino's opinion thorough, well-reasoned, and well-documented. He explained how the medical evidence was consistent with a finding that Claimant does not have lung disease or abnormality. He further explained how Claimant's breathing problems, to the degree that he has any, can be attributed to obesity and GERD. Accordingly, I give Dr. Fino's opinion more weight.

Weighing all four medical opinions together, I find that the opinion of Dr. Fino outweighs the opinions of Drs. Celko, Renn and Schaaf.[5] Accordingly, I find that Claimant has failed to establish the existence of pneumoconiosis under § 718.202(a)(4).

The record also contains evidence of two CT scans. Each scan was interpreted by two physicians as discussed previously. None of these interpretations include a diagnosis of pneumoconiosis. Therefore, the CT scans do not establish the presence of pneumoconiosis.

[5] I further note that Drs. Renn, Fino and Schaaf are all board-certified in internal medicine and pulmonary disease, while Dr. Celko is board-certified in internal medicine. While Dr. Renn is also certified in forensic medicine, I do not find that this certification provides Dr. Renn any advantage in considering the evidence in this case. Consequently, my consideration of the physician's qualifications does not change the weight I accorded each physician's opinion.

I have weighed all the relevant evidence together under 20 C.F.R. § 718.202(a) to determine whether the miner suffered from pneumoconiosis, as defined in §718.201. In summary, I find that: the x-ray evidence is in equipoise and does not establish a finding of pneumoconiosis; there is no biopsy or autopsy evidence; the CT scans do not establish pneumoconiosis; the treatment records do not establish pneumoconiosis; and, the medical opinion evidence fails to establish clinical or legal pneumoconiosis. Therefore, taken as whole, I find that pneumoconiosis has not been established under 20 C.F.R. § 718.202(a). *See, Island Creek Coal Co. v. Compton*, 211 F. 3d 203, 2000 WL 524798 (4th Cir. 2000); *Penn Allegheny Coal Co. v. Williams*, 114 F. 3d 22 (3d Cir. 1997).

Cause of Pneumoconiosis

Once it is determined that Claimant suffers from pneumoconiosis, it must be determined whether the disease arose, at least in part, out of coal mine employment. 20 C.F.R. § 718.203(a). If a miner who is suffering from pneumoconiosis was employed for ten years or more in the coal mines, then there is a rebuttable presumption that the pneumoconiosis arose out of such employment. 20 C.F.R. § 718.203(b). As I have found that Claimant was employed in the coal mines for at least 21.87 years, he would be entitled to the rebuttable presumption that his pneumoconiosis, if proven, arose out of coal mine employment. However, Claimant has failed to establish the existence of pneumoconiosis.

Evidence of Total Disability

A miner shall be considered totally disabled if either the irrebuttable presumption in § 718.304 applies, or if the miner's pulmonary or respiratory impairment, standing alone, prevents him from performing his usual coal mine work. 20 C.F.R. § 718.204(b)(1). In this case Claimant is ineligible for the irrebuttable presumption in § 718.304 because he has not been diagnosed with complicated pneumoconiosis. The regulations further provide that in the absence of contrary probative evidence, a miner's total disability shall be established by qualifying pulmonary function studies, qualifying blood gas studies, the existence of cor pulmonale with right-sided congestive heart failure, or the reasoned and documented opinion of a physician finding that Claimant's pulmonary or respiratory impairment prevents him from engaging in his usual coal mine work. 20 C.F.R. § 718.204(b)(2).

The Claimant has not established total disability with qualifying pulmonary function or arterial blood gas study results. Pulmonary function studies, performed on five separate dates, were submitted as evidence in this claim. None of these tests produced qualifying results. Arterial blood gas studies, were performed on three occasions, were also submitted, but these tests also failed to produce qualifying results. There is no evidence in record that Claimant suffered from cor pulmonale with right-sided congestive heart failure, and therefore Claimant has failed to establish total disability by that means.

Total disability can be established by the reasoned and documented opinion of a physician. Four physicians discussed the issue of whether Claimant is totally disabled in their reports. Dr. Celko initially stated that Claimant is totally disabled from his last coal mine job because of Claimant's moderate obstructive disease demonstrated on the PFT and hypoxemia shown by the ABG study. However, at his deposition, Dr. Celko changed his opinion, and stated that Claimant has some limitation, but could still do moderate physical activity from a

ventilatory standpoint. Dr. Schaaf opined that Claimant is unable to perform his coal mine employment based on significant hypoxemia and restrictive physiology along with chronic cough and sputum. Dr. Renn concluded that Claimant is not totally disabled from a respiratory standpoint. He determined that Claimant has only a mild restrictive defect based on the results of the PFTs and ABG studies. Likewise, Dr. Fino determined that Claimant is able to perform his last coal mine employment from a respiratory standpoint. He also based his findings on the PFT and ABG evidence.

Although Dr. Renn's opinion on pneumoconiosis was inconsistent, his opinion on total disability is not affected by this error. I find the opinions of both Drs. Renn and Fino well reasoned and documented and consistent with the medical evidence of record. Although Dr. Schaaf minimally explained his conclusions, his determination of total disability in light of non-qualifying testing is not persuasive. Dr. Celko's opinion was not explained or documented and changed from his initial finding of total disability; therefore I give little weight to his determination that Claimant is unable to perform his coal mine employment. Accordingly, I find that the opinions of Drs. Fino and Renn outweigh the opinions of Drs. Schaaf and Celko. Based on my findings, Claimant has not established that he is totally disabled from a respiratory standpoint.

Attorney's Fees

The award of attorney's fees under the Act is permitted only in cases in which the claimant is found to be entitled to the receipt of benefits. Because benefits are not awarded in this case, the Act prohibits the charging of any fee to the Claimant for the representation services rendered to her in pursuit of the claim.

CONCLUSION

As Claimant has not established that he has pneumoconiosis or that he is totally disabled, he has not established all elements of entitlement, I conclude that he has not established entitlement to benefits under the Act.

ORDER

The claim of R.S. for Black Lung benefits under the Act is hereby DENIED.

A

MICHAEL P. LESNIAK
Administrative Law Judge

NOTICE OF APPEAL RIGHTS: If you are dissatisfied with the administrative law judge's decision, you may file an appeal with the Benefits Review Board ("Board"). To be timely, your appeal must be filed with the Board within thirty (30) days from the date on which the administrative law judge's decision is filed with the district director's office. *See* 20 C.F.R.

§§ 725.478 and 725.479. The address of the Board is: Benefits Review Board, U.S. Department of Labor, P.O. Box 37601, Washington, DC 20013-7601. Your appeal is considered filed on the date it is received in the Office of the Clerk of the Board, unless the appeal is sent by mail and the Board determines that the U.S. Postal Service postmark, or other reliable evidence establishing the mailing date, may be used. *See* 20 C.F.R. § 802.207. Once an appeal is filed, all inquiries and correspondence should be directed to the Board.

After receipt of an appeal, the Board will issue a notice to all parties acknowledging receipt of the appeal and advising them as to any further action needed.

At the time you file an appeal with the Board, you must also send a copy of the appeal letter to Allen Feldman, Associate Solicitor, Black Lung and Longshore Legal Services, U.S. Department of Labor, 200 Constitution Avenue, NW, Room N-2117, Washington, DC 20210. *See* 20 C.F.R. § 725.481.

If an appeal is not timely filed with the Board, the administrative law judge's decision becomes the final order of the Secretary of Labor pursuant to 20 C.F.R. § 725.479(a).

NOTICE OF PUBLIC HEARING: By statute and regulation, black lung hearings are open to the public. 30 U.S.C. § 932(a) (incorporating 33 U.S.C. § 923(b)); 20 C.F.R. § 725.464. Under e-FOIA, final agency decisions are required to be made available via telecommunications, which under current technology is accomplished by posting on an agency web site. *See* 5 U.S.C. § 552(a)(2)(E). *See also* Privacy Act of 1974; Publication of Routine Uses, 67 Fed. Reg. 16815 (2002) (DOL/OALJ-2). It is the policy of the Department of Labor to avoid use of the Claimant's name in case-related documents that are posted to a Department of Labor web site. Thus, the final ALJ decision will be referenced by the Claimant's initials in the caption and only refer to the Claimant by the term "Claimant" in the body of the decision. If an appeal is taken to the Benefits Review Board, it will follow the same policy. This policy does not mean that the Claimant's name or the fact that the Claimant has a case pending before an ALJ is a secret.